TO BE RETAINED IN STUDENT FILE

PHOTO/ACADEMIC WORK PERMISSION FORM

On occasion, ____________________________(school) uses photos and/or academic work of students in school/parish publications to share information about the school. School publications include, but are not limited to: the website, school yearbook, student academic work, advertisements, annual reports, posters, newsletters, parish bulletins and other public relations material.

In addition, local news organizations may hear of our activities or events, and our school may invite or allow them to photograph or record our events.

Please check and sign below:

My child's photo or academic work may be published in any format including group or individual photos.

My child's photo or academic work may not be published in any format including group or individual photos.

PLEASE PRINT:

Name of Student __________________ Grade __

Name of Student __________________ Grade __

Name of Student __________________ Grade __

Name of Student

Name ofParent/Guardian ____

Date

Parent/Guardian Signature

This form will remain in effect until the parent/guardian requests a change in writing.

Uyou do not return this form by ______________ (date), it will be assumed that you give permission for your child's photo or academic work to be included in any form of communication.

To be updated by parent/guardian/physician annually

Physician's Order

Student | Grade

Medication! Health Care Treatment | Dosage | Time(s) to be administered

Intended effect of this medication | Expected side effects, if any

Other medications the student is taking

1) May student self-administer medication under supervision of school personnel who do not have medical training?

   (Please circle) YES NO

2) For ASTHMA and ALLERGY CONDITIONS ONLY;
   I certifY that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

   (Please circle) YES NO

   I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.

   (P lease circle) YES NO

Administration Instructions:

Physician's /Prescriber's Signature | Date Signed

Physician's/ Prescriber's Name (PRINT) | Emergency telephone number

Address | City, State, Zip Code

Medication Authorization approved or denied aQd signed this __ day of ________________ ,
(Please circle one)

20 _, by on behalf of
Signature of Pl"incipal

________________ School, ______________________________________ , Illinois

To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

________________ SCHOOL, , ILLINOIS

Student Name (Last, First, Middle) Date of Birth Grade Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned this entire form to the School and the Medication in the original labeled container as dispensed (prescription medication) or the manufacturer's labeled container (nonprescrip:tion medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Parent/Guardian Permission and Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medication Procedures)"lawfully prescribed medication and non-prescribed medication in the manner described in the Physician's Order {Reverse side}. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices.

I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed this form in the space provided below.

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration. In addition, I agree to hold harnlless and indemnity the School, the Catholic Bishop of Chicago, the parish, and their employees or agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administrat,ion of said medication.

Parent/Guardian (PRINT)

Parent/Guardian (SIGNATURE)

Address

City, State, Zip Code

Home Phone Business Phone

Parent/Guardian (PRINT)

Parent/Guardian (SIGNA TURE)

Address

City, State, Zip Code

Home Phone Business Phone

To be completed by parent/guardian for each child and submitted to the school annually

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL ____ _

STUDENT NAME	DATE OF BIRTH	GRADE	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT

ParentiGuardian __________________________________ _ ParentiGuardian __________________________________ _

Home Phone ( ) _________ Work (
Cell Phone ( ) _________ _____________________ _

Home Phone ( ) ________Work (
Cell Phone (r) _________ ____________________ _

Name of Student's Physician ____ _ Phone (

Address ____ City _______________________ State ______________ _

Medical Insurance Provider ____Policy/Insurance # ________________ _

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME _______________________________________ _ . RELATIONSHIP TO STUDENT _ _ _ _ _ _ _ _
Phone 1 { Phone 2 ( ) ___________________ _

NAME ____ _ RELATIONSHIP TO STUDENT __________ __________
Phone 1 { Phone 2 ( ) _____________________ _

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, IIwe hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services as are deemed necessary. I!We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

PARENT/GUARDIAN SIGNATURE DATE

PARENT/GUARDIAN SIGNATURE DATE

THIS FORM WILL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.

Archdiocese of Chicago
Office of Catholic Schools
June 2008

This permission form is to be distributed on school stationery.

FIELD TRIP PERMISSION FORM

DESTINATION ________ ____ _

DATE ~ __________ _ GRADE/CLASS ___________________

DEPARTURE TIME ___________________________ ~RETURN TIME ___________________________ _

TEACHER/SUPERVISOR. ____ _

PURPOSE OF THE FIELD TRIP

Please note the following:

Students will wear school uniforms

__ Students may wear casual clothes suited for the field trip and in accord with school procedures __

Students will bring their lunches (identified with name and grade)

__ Lunch will be provided for the students

__ Students may purchase lunches at their own expense

Other:

__ Cost for the field trip is $ __________________ _ due by ___________________________ _

Transportation

__ Bus - provided by ____ _

__ Public - provided by ____ _

__ Walking

Please PRINT student's first and last name and date of birth

FIRST NAME LAST NAME DATE of BIRTH

has permission to attend this field trip.

Signature of
Parent/Guardian __________________ Date ____ _

(Please place the permission form and the required fee in an envelope. lnclude student's name and room number.)

A copy of this form is retained in the school office. A copy will accompany the teacher on the field trip.